SERFF Tracking Number:	*AFLA-126022026*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*41446*
Company Tracking Number:	*A63004RAR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life*		
Project Name/Number:	*A63004RAR/*		

Filing at a Glance

Company: American Family Life Assurance Company of Columbus

Product Name: Life	SERFF Tr Num: AFLA-126022026	State: ArkansasLH
TOI: L08 Life - Other	SERFF Status: Closed	State Tr Num: 41446
Sub-TOI: L08.000 Life - Other	Co Tr Num: A63004RAR	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Author: Connie Gates	Disposition Date: 02/09/2009
	Date Submitted: 02/04/2009	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: A63004RAR	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 10/16/2008
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 02/09/2009	Explanation for Other Group Market Type:
	State Status Changed: 02/09/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

RE: PAYROLL LIFE APPLICATION A63004RAR

Dear Mr. Musgrove:

The above referenced form is submitted for your review and approval. This form will be used with Policy Form A63200AR, which was previously approved by your department on October 14, 2005. A similar version of this application was approved by your department on November 30, 2007. Nebraska, our state of domicile, approved a

SERFF Tracking Number:	*AFLA-126022026*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*41446*
Company Tracking Number:	*A63004RAR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life*		
Project Name/Number:	*A63004RAR/*		

similar version of this form on October 16, 2008. The application has been revised in order to improve and provide consistency in our underwriting.

Payroll Application Form A63004RAR will be used to make application for Policy Form A63200AR on a payroll basis when the applicant wishes to apply for only $25,000 worth of term insurance with no riders.

I certify that the form submitted herewith meets the applicable provisions of Rule and Regulation 19 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of the Arkansas Insurance Department.

I certify the following form complies with the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

This is to certify that the following forms comply with the requirements of Arkansas Statute Annotated- Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act.

FLESCH Score

PAYROLL LIFE APPLICATION A63004RAR
66.877

The rates and actuarial memo remain the same. We have submitted the appropriate filing fee by EFT, accompanying fee certification form.

This filing has been prepared by Connie Gates. Should you have any questions or comments concerning this submission, please do not hesitate to call her collect at (706) 596-5048, by fax at (706) 660-7080 or email at cgates@aflac.com.

SERFF Tracking Number:	*AFLA-126022026*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*41446*
Company Tracking Number:	*A63004RAR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life*		
Project Name/Number:	*A63004RAR/*		

Company and Contact

Filing Contact Information

Connie Gates, Policy Analyst
1932 Wynnton Road
Columbus, GA 31999

cgates@aflac.com
(706) 596-5048 [Phone]
(706) 660-7080[FAX]

Filing Company Information

American Family Life Assurance Company of Columbus
1932 Wynnton Road
Columbus, GA 31999
(706) 323-3431 ext. [Phone]

CoCode: 60380
Group Code:
Group Name:
FEIN Number: 58-0663085

State of Domicile: Nebraska
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	one application $20.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Family Life Assurance Company of Columbus	$20.00	02/04/2009	25505355

SERFF Tracking Number:	*AFLA-126022026*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*41446*
Company Tracking Number:	*A63004RAR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life*		
Project Name/Number:	*A63004RAR/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	02/09/2009	02/09/2009

SERFF Tracking Number:	*AFLA-126022026*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*41446*
Company Tracking Number:	*A63004RAR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life*		
Project Name/Number:	*A63004RAR/*		

Disposition

Disposition Date: 02/09/2009
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AFLA-126022026*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*41446*
Company Tracking Number:	*A63004RAR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life*		
Project Name/Number:	*A63004RAR/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Payroll Life Application		Yes

SERFF Tracking Number:	*AFLA-126022026*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*41446*
Company Tracking Number:	*A63004RAR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life*		
Project Name/Number:	*A63004RAR/*		

Form Schedule

Lead Form Number: A63004RAR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	A63004RAR	Application/ Enrollment Form	Payroll Life Application	Initial		67	A63004RAR.pdf

Payroll

Aflac's Protector Series
Application for Payroll Life Insurance (Policy Form Series A63200)
Application to American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters: Columbus, Georgia 31999]

❑ New

Policy Number

Please Print in Black Ink – To Be Completed by Proposed Insured/Employee

Proposed Insured's/Employee's Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP Code _____

Home Telephone ( ) _____ Business Telephone ( ) _____ Best Time to Call _____

Name of Employer _____ Department No. _____

Employee ID No. _____ Occupation _____

Email Address (optional) _____

Do you have any other life coverage, not to include group guaranteed-issue life, with Aflac or in the last year, have you been declined or postponed for medical reasons on any life insurance application with Aflac? If yes, please do not submit this application. ❑ Yes ❑ No

Is the purchase of this policy intended to replace any life insurance or annuity now in force? If yes, please read and sign the Replacement Notice provided by your associate/agent and provide the policy number here _____. ❑ Yes ❑ No

BENEFIT AMOUNTS

Coverage for the Applicant Only	**Issue Ages**	**Face Amount of Insurance**
☐ 10-Year Term Policy (Series A63200)	18–64	$25,000

PLEASE NOTE: We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. If there is no beneficiary, Aflac will pay any applicable benefit to your estate.

PRIMARY BENEFICIARY - PLEASE PRINT

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

CONTINGENT BENEFICIARY - PLEASE PRINT

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? ❑ Yes ❑ No
This information will be verified at the time of claim.

Billing Method:	**Mode:**		
❑ Payroll Deduction	❑ 01 Weekly	❑ 01 Semimonthly	❑ 06 Semiannual
❑ Bank Draft (B/D, ACH)	❑ 01 14-Day Biweekly	❑ 01 Monthly	❑ 12 Annual
❑ Credit Card (C/C)	❑ 01 28-Day Biweekly	❑ 03 Quarterly	

PLEASE NOTE: If B/D or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Billable Premium $ _____ Premium Collected $ _____

PLEASE COMPLETE THE FOLLOWING QUESTIONS

1. Is anyone to be covered currently disabled due to sickness or injury, or has anyone to be covered been out of work or disabled due to sickness or injury more than 5 consecutive days within the last 12 months (excluding routine childbirth)? ❑Yes ❑No
2. Has anyone to be covered been hospitalized more than 24 hours within the last 12 months for reasons other than routine childbirth? ❑Yes ❑No
3. Does anyone to be covered have any condition for which any medical procedure (including but not limited to surgery, child delivery, organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? ❑Yes ❑No
4. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑Yes ❑No
5. Has anyone to be covered, within the last five years: been convicted of a felony; been charged two or more times with operating a vehicle while under the influence of alcohol or drugs; been charged three or more times with a moving violation; or is currently on parole or incarcerated in a correctional institution? ❑Yes ❑No
6. Does anyone to be covered currently have or in the last 12 months, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑Yes ❑No

AIDS
HIV-positive diagnosis
Systemic lupus
muscular dystrophy
Parkinson's Disease
cystic fibrosis
pulmonary hypertension
renal hypertension
Crohn's disease
Ileitis
regional enteritis
ulcerative colitis
ulcerative proctitis
vascular insufficiency (circulatory problems)
diabetes (Type II) diagnosed prior to age 30
any sort of back, neck, or joint disorder
carpal tunnel syndrome
psoriatic arthritis
rheumatoid arthritis
sciatica

7. Within the last 5 years has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑Yes ❑No

heart attack	diabetes treated with insulin
cardiomyopathy	diabetes with complications to include nephropathy;
bypass/stents/angioplasty	neuropathy; or retinopathy
atrial fibrillation	kidney disease or disorder (not including stones)
implant of pacemaker/defibrillator	liver disease or disorder (excluding Hepatitis A)
heart surgery (including valve replacement	fibromyalgia
or correction)	chronic fatigue syndrome
congestive heart failure	sarcoidosis
stroke/TIA	multiple sclerosis
chronic obstructive pulmonary disease (COPD)	alcohol or drug abuse
emphysema	internal cancer (to include myelodysplastic blood
pulmonary fibrosis	disorder and myeloproliferative blood disorder)
diabetes and used tobacco after diagnosis	melanoma (Clark's Level III or higher, or a Breslow Level greater than 1.5 mm)

If you answered Yes to any question 1 - 7, you are not eligible for coverage; therefore, do not submit this application.

APPLICANT'S STATEMENTS AND AGREEMENTS

I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.

I acknowledge receipt of, if applicable: ❑ Replacement Notice ❑ Life Buyer's Guide

I understand that: (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) Aflac is not bound by any statement made by me or any associate/agent of Aflac, unless written herein; (3) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (4) the policy, together with this application, endorsements, benefit agreements, Riders, and attached papers, if any, constitutes the entire contract of insurance; and (5) no change to the policy will be valid until approved by Aflac's president and secretary and noted in or attached to the policy.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you, except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at [1-866-692-6901 (TTY 1-866-346-3642)].

If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its web site at www.mib.com.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

I have read, or had read to me, the completed application. I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy.

I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf, and I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me by my associate/agent.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured/Applicant's Signature (X) _____

I certify that I personally saw the applicant when the application was completed, and each question was asked of the applicant and answered as recorded. All answers are correct to the best of my knowledge. To the best of my knowledge, this policy **will ❑ will not ❑** replace or change any existing life insurance or annuity policy(ies).

Associate's/Agent's Signature_____

Date_____ Associate's/Agent's Writing Number_____ Sit. Code_____

Writing Associate/Agent: Please complete the following – it will become part of the policy.
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),
CLIENT SERVICES AND ADMINISTRATION,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.]

Associate/Agent's Name _____

Associate/Agent's Address _____ Telephone _____

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR TOLL-FREE 1-800-852-5494.

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.]

SERFF Tracking Number:	*AFLA-126022026*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*41446*
Company Tracking Number:	*A63004RAR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life*		
Project Name/Number:	*A63004RAR/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AFLA-126022026*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*41446*
Company Tracking Number:	*A63004RAR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Life*		
Project Name/Number:	*A63004RAR/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Flesch Certification 02/04/2009

Comments:

Attachments:

AR A63004R STDCOMBOLETTER.pdf

AR A63004rar FEECERT.pdf

Deborah T. Grantham
AIRC, HIA, ACS
Second Vice President
Compliance Department

February 04, 2009

Mr. Joe Musgrove
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

NAIC# 60380

RE: PAYROLL LIFE APPLICATION A63004RAR

Dear Mr. Musgrove:

The above referenced form is submitted for your review and approval. This form will be used with Policy Form A63200AR, which was previously approved by your department on October 14, 2005. A similar version of this application was approved by your department on November 30, 2007. Nebraska, our state of domicile, approved a similar version of this form on October 16, 2008. The application has been revised in order to improve and provide consistency in our underwriting.

Payroll Application Form A63004RAR will be used to make application for Policy Form A63200AR on a payroll basis when the applicant wishes to apply for only $25,000 worth of term insurance with no riders.

I certify that the form submitted herewith meets the applicable provisions of Rule and Regulation 19 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of the Arkansas Insurance Department.

I certify the following form complies with the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

This is to certify that the following forms comply with the requirements of Arkansas Statute Annotated- Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act.

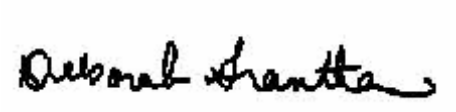
	FLESCH Score
PAYROLL LIFE APPLICATION A63004RAR	66.877

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters · 1932 Wynnton Road · Columbus, Georgia 31999
706.660.7077 tel ·706.660.7080 fax · dgrantham@aflac.com · aflac.com

The rates and actuarial memo remain the same. We have submitted the appropriate filing fee by EFT, accompanying fee certification form.

This filing has been prepared by Connie Gates. Should you have any questions or comments concerning this submission, please do not hesitate to call her collect at (706) 596-5048, by fax at (706) 660-7080 or email at cgates@aflac.com.

Sincerely,



Deborah T. Grantham
DTG/CG/cg
Enclosures

ARKANSAS INSURANCE DEPARTMENT

400 University Tower Building
1123 South University Avenue
Little Rock, Arkansas 72204

501-686-2900

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (Aflac)

Company NAIC Code: 60380

Company Contact Person & Telephone # Connie Gates (706) 596-5048

* *

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.	* ____x $50 = ________ ** Retaliatory
Life and/or Disability – Filing and review of each rate filing or loss ration guarantee filing, per each insurer.	* _____ x $50 = ________ ** Retaliatory
Life and/or Disability Policy, Contract or annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.	* 1 x $20 = 20 ** Retaliatory
Policy and contract forms, all lines, filing corrections in previously filed policy and contract forms.	* ____x $20 = ________ ** Retaliatory
Life and/or Disability: Filing and review of insurer's advertisements, per advertisement, per each insurer.	* ____x $25 = ________ ** Retaliatory

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority * ____ x $400 = _____

Filing to amend Certificate of Authority *** ____ x $100 = _____

* THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.

*** THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. § 23-61-401.